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On August 27, the Health Resources and Services Administration released draft guidance clarifying the definition of a 340B patient, contract pharmacy arrangements, audit procedures, and other processes. **Read below**

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TAKE ACTION! Ask Congress to Help Stop Proposed Medicare Cuts to Cancer Care

We need your help preventing CMS' proposed Medicare cut to freestanding radiation therapy centers from taking effect in 2016. If CMS proceeds with cuts as drafted in its proposed rule, Medicare reimbursement for prostate and breast cancer treatments will be cut by 25 percent and 19 percent, respectively.

If you haven't done so already, please ask your lawmakers in Congress to take a stand against the proposed cuts to radiation oncology by signing a letter to CMS Acting Administrator Andy Slavitt, led by Senators Debbie Stabenow (D-MI) and Richard Burr (R-NC) in the Senate and Congressmen Devin Nunes (R-CA) and Paul Tonko (D-NY) in the House of Representatives, which asks CMS to reconsider their proposed rule and prevent proposed cuts to freestanding radiation therapy centers.

To write or call your lawmakers in Congress, CLICK HERE.

The US Oncology Network on August 8 submitted comments to CMS on the proposed PFS rule for 2016. The Network comments support the proposals that will benefit community cancer care while pushing back on the proposals that would harm patients and limit access to integrated community cancer care. Some of the topics covered in the comments include:

- Payment Modifications for Radiation Therapy and Image Guidance Services
- Payment for Flow Cytometry
- Application of the Misvalued Code Target
- Phase-In of Significant Relative Value Unit (RVU) Reductions
- Incident-To Proposals
- Payment for Advance Care Planning
- Implementation of the Appropriate Use Criteria (AUC) Program
- Group Practice Reporting Option (GPRO) Self-Nomination Flexibility under the Physician Quality Reporting Program (PQRS) and Physician Value-Based Payment Modifier (VM) Program
- Application of VM to Pioneer Accountable Care Organization (ACO) Model, Comprehensive Primary Care Initiative, or other Innovation Center Model Participants
- Site-Neutral Payment Policy for Cancer Care

To read The US Oncology Network comments to CMS, CLICK HERE**.**

HRSA Releases 340B Discount Drug Program Guidance

On August 27, the Health Resources and Services Administration (HRSA) released a draft omnibus guidance clarifying the definition of a 340B patient, contract pharmacy

arrangements, audit procedures, and other processes. The guidance was written to address critics decrying a lack of oversight, allowing the program to become too inclusive with one third of all hospitals taking advantage of it.

HRSA said that the guidance allows 340B providers to "remain able to carry out the intent of the 340B program – to stretch the scarce Federal resources as far as possible" while strengthening program integrity and oversight. Among the proposed changes in HRSA's guidance are an increase in conditions for patients to be covered under the program, including:

1. The individual receives services at a facility or clinic that is registered for the program and listed on the pubic 340B database;
2. The individual receives a service provided by a covered entity who is either employed by or an independent contractor for the covered entity, so that the entity can bill on behalf of the provider;
3. The individual's drug is ordered or prescribed by the provider as a result of the service described;
4. The individual's healthcare is consistent with the scope of the federal grant, project, designation, or contract;
5. The individual's drug is ordered or prescribed pursuant to a healthcare service classified as outpatient; and
6. The individual's patient records are accessible to the covered entity and that the entity is responsible for care.

Those opposed to the newly proposed guidance suggest that the patient limits would negatively impact access to the program among small and rural hospitals.

HRSA is taking public comments on the proposal until October 27, 2015.

To view the full Omnibus Guidance, CLICK HERE.

New CBO Projections Predict Lower Long-Term Medicare Spending

Lower costs for medical services and labor have reduced the 10-year projected cost of Medicare and Medicaid by $89 billion, the Congressional Budget Office (CBO) said in an updated report released August 25.

While the CBO had previously estimated Medicare spending will drop by $49 billion — or less than 1 percent — from 2015 and 2024, federal spending on major health care programs will jump by $67 billion in 2015 — or about 9 percent. Most of this short-term increase is due to the Affordable Care Act (ACA), including Medicaid expansion and the financial assistance to help people purchase health insurance.

A Medicare physician payment “fix,” which maintains Medicare physician payment increases to the current rate through 2024 will cost $131 billion over 10 years, according to the CBO.

To read the updated CBO estimates, CLICK HERE.

CMS Studies Shift Toward Hospital-Based Physician Practices

On January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) will require two new mandatory Medicare billing practices for physicians and hospitals. The goal of these requirements is to help CMS collect data on the frequency of, type of, and payment for services furnished in off-campus provider-based hospital departments.

In its 2015 Medicare Physician Fee Schedule final rule, CMS stated it will "seek a better understanding regarding the growing trend toward hospital acquisition of physicians' offices and how the subsequent treatment of those locations as off-campus provider-based outpatient departments affects payments under PFS and beneficiary cost-sharing."

Starting January 1 of next year, physicians must use either new POS code 19 or revised POS code 22 on all health insurance claims they submit to Medicare Part B contractors.

New/Revised Codes for Physician Reporting	
POS Code 19	A portion of an *off-campus hospital provider-based department*, which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
POS Code 22	A portion of a *hospital’s main campus*, which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

The following billing details are also included in the memo:

- *The three-day payment rule will also apply to services billed with POS code 19. Payments for services provided to outpatients who are later admitted as inpatients within three days (or, in the case of noninpatient prospective payment systems [IPPS] hospitals, one day) are bundled when the patient is seen in a wholly owned or wholly operated physician practice. The three-day payment window applies to diagnostic and nondiagnostic services that are*

clinically related to the reason for the patient's inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same.

- *Claims for covered services rendered in an off-campus outpatient hospital setting (or in an on-campus outpatient hospital setting, if payable by Medicare) will be paid at the facility rate. The payment policies that currently apply to POS 22 will continue to apply to this POS, and will now also apply to POS 19 unless otherwise stated.*

To learn more, CLICK HERE.